Section 7. Application and Case Processing

7.1 Request for Application

An individual or his/her guardian may apply for the Medicaid Support Services Waiver through either the local Bureau of Developmental Disabilities Services (BDDS) office or a participating local Area Agency on Aging office. Individuals (or their guardians) have the right to apply without question or delay.

To apply for the Support Services Waiver the individual or guardian must complete, sign, and date an *Application for Long-Term Care Services - State Form 45943*. (The time of day must also be noted on the application.) Other individual or agency representatives may assist the individual or guardian in completing the application form and forwarding it to the BDDS or AAA office serving the county in which the individual currently resides. (The application may be submitted in person, by mail or FAX.)

After the State Form 45943 is completed, signed and dated, the BDDS or AAA office must enter the individual's application/demographic information into the DART or INsite database and transmit the record to the DDARS database.

Within 14 days of receiving the Waiver application, the BDDS or AAA staff must have contact with the individual, his/her guardian, (or if applicable, the Ongoing Targeted Case Manager or other individual or agency representative who is assisting the individual in completing the application) and discuss the process for determining eligibility for the Waiver (diagnosis/documentation of a developmental disability, Medicaid eligibility, and level of care) and will arrange with the client/guardian/advocate to obtain information necessary for the eligibility determination.

If the applicant is not a Medicaid recipient, he/she will be immediately referred to the local Division of Family and Children to apply for Medicaid. If the individual has not been determined eligible for Targeted Case Management, the Intake Case Manager must follow the steps outlined in the Targeted Case Management Operations Manual to determine if the individual meets the State's developmental disability eligibility criteria. If the individual is eligible for developmental disability services and is a current Medicaid recipient, the Intake Case Manager is to present to the

individual or guardian, the current list of certified Ongoing Targeted Case Managers serving the county where the person resides.

7.2 Initial Level of Care Determination

An individual must meet the level of care required for placement in an Intermediate Care Facility for the Mentally Retarded (or Developmentally Disabled) (ICF/MR) to be eligible for community services through the Support Services Waiver. Applicants for the Support Services Waiver must be evaluated to determine if they meet the ICF/MR Level of Care (i.e. are at risk of institutionalization).

7.2.1 Level of Care

To complete a level of care determination, the case manager or case manager designee must obtain and review the following:

- **A completed Medicaid Form 450B medical form (sections 1, 2, 3, and 6) signed and dated by a physician within the past year.**

The case manager or case manager designee must perform and include in the level of care packet:

- **A Developmental Disabilities Profile (DDP)**[*];

(The DDP is not to be used for children under the age of five(5) years. For these children an age-referenced assessment must be completed.)

Information necessary to complete the DDP must be obtained through:

1) **Psychological records including I.Q. score;**
2) **Social assessment records;**
3) **Medical records; or**
4) **Other records that are a valid reflection of the individual.**

(#1-4 may be older than one year if the QMRP certifies that they continue to be a valid reflection of the individual. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be

[*] The DDP (as well as the 450B) must be done annually with the annual redetermination of Level of Care.

obtained through the local BDDS-contracted diagnostic evaluation (D&E) team.)

The level of care determination must be made by a case manager who is a QMRP. The determination must be recorded by the QMRP utilizing the INsite or DART database and transmitted to the DDARS database.

For children under age (five) 5, the following information must be submitted to OMPP for the level of care determination:

- Transmittal Form for Medicaid Level of Care Eligibility (HCBS Form 7):
- A completed Medicaid Form 450B (sections 1,2,3, and 6) signed and dated by a physician within the past year;
- Additional psychological, social, and medical records as necessary to provide a current and valid reflection of the child. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted diagnostic evaluation (D&E) team.)

If the case manger, determines that the applicant does not meet ICF/MR level of care and therefore is ineligible for services under the Support Services Waiver, the intake case manager must complete a Notice of Action form (*HCBS Form 5*), and provide a copy of the form, its accompanying *Appeal Rights as an HCBS Waiver Services Recipient,* and an explanation of the decision to the individual or guardian. *A Data Entry Worksheet (HCBS DE T/D)* must be completed, entered into the database, and transmitted to DDARS.

The case manager may discuss other service options with the individual and guardian. An individual who does not meet level of care criteria and consequently, is not eligible for the Support Services Waiver, may still be eligible for Targeted Case Management if he/she is a Medicaid recipient and developmentally disabled according to the State definition.

If the individual is eligible for Targeted Case Management and does not already have an ongoing case manager, he/she should choose one at this time.

7.3 Initial Plan of Care and Cost Comparison Budget Development

7.3.1. Plan of Care

The BDDS, AAA, or independent case manager is responsible for facilitating the person-centered plan with the individual, guardian, and additional participants who the individual may request.

The case manager develops a POC based upon the Person Centered Planning/Support Plan process (Sections 12 and 13) that includes the full range of appropriate services, delivered in a planned, coordinated, efficient, and effective manner. The POC includes the proposed Medicaid Waiver services, (targeted) case management, and other Medicaid State plan services, other publicly funded services, and informal supports that the individual receives/will receive. Additionally, unmet needs and emergency back-up plans must be addressed by the case manager on the POC.

The case manager is responsible for coordinating the proposed Waiver funds with any other proposed sources of public funding. Medicaid funding (Waiver or regular Medicaid services) should be utilized first to fund services whenever possible. For example, supported employment follow-along services should be funded through the Support Services Waiver rather than Title XX. Waiver funding should be utilized before State line item or CHOICE funding for comparable services.

7.3.2. Cost Comparison Budget

After the POC has been developed, the case manager develops the proposed Cost Comparison Budget (CCB). The CCB must include a written explanation of the individual's need for the proposed services, the manner by which the services protect the individual's health and safety, the individual's needs that will not be met, and a description of emergency back-up plans.

The cost of services on an individual's CCB shall not exceed $13,500 per year. Of this amount, no more than $2,000 per year may be allocated for respite care. (This is not a calendar year, but is determined as one year from the Waiver start date.)

The case manager must review the POC and CCB with the individual/guardian and the individual or guardian must sign indicating acceptance of the POC/CCB. The individual/guardian must also be informed (and sign to document that he/she has been informed of):

a) The right to choose any certified Waiver service provider when selecting Waiver service providers, including the Targeted Case Manager.
b) The right to choose between institutional placement and Home and Community-Based Waiver Services.

The case manager must enter the proposed POC and CCB into the INsite database and electronically transmit the information to the BDDS office serving the county in which the individual currently resides.

Note: The POC and CCB may be developed during the level of care process if there is a good indication that the individual will meet level of care. Otherwise, the information is to be developed and submitted to the local BDDS office within 14 calendar days of the individual's level of care approval.

7.4 State Authorization of the Plan of Care and Cost Comparison Budget

The local BDDS Service Coordinator will review the POC and Cost Comparison Budget within 5 days of receiving it electronically and will confirm that:

a) The identified needs of the individual will be met;
b) The health and safety of the individual will be assured; and
c) BDDS funds to supplement the CCB are available if required.

The Service Coordinator may request additional information from the case manager to assist in reviewing the packet.

If the Service Coordinator denies the POC and CCB, a denial letter must be transmitted to the case manager. Within 5 days of the receipt of this denial, the case manager must provide to the individual/guardian, a completed *Notice of Action HCBS Form 5*, denial letter, the *Appeal Rights as an HCBS Waiver Services Recipient*, and must give an explanation to the individual or guardian of the decision to deny.

If the Service Coordinator approved the POC and CCB, they are electronically transmitted to the Support Services Waiver Specialist in IDDARS.

Within 7 calendar days of receipt of an approval from the Service Coordinator, the Support Services Waiver Specialist will review the POC and CCB and confirm the following:

a) The individual is a current Medicaid recipient within the category of "Aged, Blind, Disabled";
b) The individual has a current ICF/MR level of care approval for the Waiver;
c) The individual has been targeted for an available Waiver slot;
d) The individual's identified needs will be met and health and safety will be assured;
e) The costs are consistent with identified needs of the individual and the services to be provided;
f) That the total cost of Medicaid Waiver services for the individual does not exceed $13,500 annually and the cost or respite care does not exceed $2,000 annually;
g) The individual or guardian has signed, indicating acceptance of, the POC and CCB; signed that he/she has been offered choice of certified Waiver service providers, and signed that he/she has chosen Waiver services over services in an institution.

The Support Services Waiver Specialist at IDDARS may request additional information from the case manager and BDDS to assist in reviewing the packet.

If the Support Services Waiver Specialist denies the POC and CCB, a denial letter must be transmitted to the case manager and BDDS. Within 5 calendar days of receipt of the denial, the case manager must complete and provide a copy of a *Notice of Action HCBS Form 5,* the *Appeal Rights as an HCBS Waiver Services Recipient*, and an explanation of the decision to deny to the individual or guardian. The case manager should discuss other service options with the individual and guardian.

If the Support Services Waiver Specialist approves the POC and CCB, the approval letter is to be transmitted to the case manager and BDDS. The case manager must notify the individual or guardian within 5 calendar days of receipt of the approval and provide a copy of the approval letter.

If the Support Services Waiver Specialist approves the POC and CCB pending Medicaid eligibility, disenrollment of a child from Hoosier Healthwise, level of care approval, facility discharge, or other reasons, the pending approval letter is to be transmitted to the case manager and BDDS. The case manger must notify the individual or guardian within 5

calendar days of receipt of the approval and provide a copy of the approval letter. The case manger must notify the Support Services Waiver Specialist when the pending issues have been resolved and the Support Services Waiver Specialist will issue an approval decision letter.

7.5 Initial Plan of Care Implementation

An individual cannot begin Waiver services prior to the approval of the initial POC and CCB by the Support Services Waiver Specialist. If the Support Services Waiver Specialist issues an approval letter, pending certain conditions being met, those conditions must be resolved prior to the start of the individual's Waiver services.

If the individual's Medicaid eligibility is approved pending Waiver approval, the case manager is to notify the Division of Family and Children caseworker when the Waiver has been approved. The caseworker and case manager are to coordinate the Medicaid eligibility date and Waiver start date. (If Medicaid eligibility depends on eligibility for the Waiver, the Medicaid start date is usually the first day of the month following approval of the POC and CCB.) The case manager must verify the Waiver effective date/start date with the Support Services Waiver Specialist prior to completing the *Notice of Action Form.*

If an individual is a Hoosier Healthwise or other Medicaid managed care program participant, the case manager must contact the Managed Care Benefit Advocate to coordinate the managed care program stop date and Waiver start date. (Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive Waiver services that are not related to the terminal condition and are not duplicative of hospice care.) The case manager and Managed Care Benefit Advocate must inform the individual's parent or guardian of his/her options to assure he/she makes an informed choice.

When the POC and CCB are approved by the Support Services Waiver Specialist, pending facility discharge, the case manager must notify the Support Services Waiver Specialist the day after the individual is discharged form the facility and within 5 days the case manager must;

a) Complete and mail the *Notice of Action HCBS Form 5* and copies of the POC and CCB to the individual or guardian;
b) Mail copies of the *Notice of Action*, POC and CCB to the Waiver service providers;

c) Mail copies of the *Notice of Action* to the local county DFC office; and
d) If necessary, update POC information in the INsite database and electronically transmit the information to the DDARS database.

Within 5 calendar days after the individual begins Waiver services, the Support Services Waiver Specialist must generate a report from the INsite database to notify OMPP to enter the following information in the Indiana AIM database;

a) Waiver start date;
b) Waiver level of care code; and
c) If applicable, facility discharge date.

7.6 Maintenance of Records

Records of evaluations (and re-evaluations) of level of care will be maintained in the Area Agency of Aging, the local Bureau of Developmental Disabilities Services office, or with the independent case manager/independent agency (the entity that evaluated or re-evaluated the individual) for a minimum of three years following the determination.

7.7 Authorization of Medical Equipment and Supplies

Specialized medical equipment/supplies as specified in the Waiver, may be authorized when necessary to enable the individual to increase his or her ability to function in a home and community-based setting with independence and physical safety.

These services must be necessary to prevent or delay institutionalization as defined in the individual's POC.

Reimbursement is not available for services that:

a. Are not allowable under current Medicaid Waiver guidelines;
b. Are available under the Medicaid State Plan as prior authorized services;
c. Are available under the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act, as amended;
d. Are not included in the individual's POC; or
e. Have not been authorized via a *Request for Approval to Authorize Services - Form BAIS 0014).*

The case manager must obtain a physician's order for specialized medical equipment or supplies prior to including the service in the individual's POC.

The case manager must obtain a Medicaid prior authorization review and denial of specialized medical equipment and supplies before including them in the individual's POC.

Medicaid prior authorization review is not required for Personal Emergency Response Systems.

For an individual who will be moving from a facility, the case manager must indicate that the specialized medical equipment and supplies will be used by the individual following discharge from the facility.

Before including specialized medical equipment and supplies costing more that $500 in the individual's POC, the case manager must obtain an evaluation by an occupational therapist, a physical therapist, speech therapist, audiologist, or rehabilitation engineer as appropriate to determine the specific needs of the individual. Specifications are utilized to obtain three bids from service providers.

Note:

a. If three bids cannot be obtained, due solely to a lack of qualified service providers in geographic proximity to the individual, the case manager must provide a written explanation as to why the three bids were not obtained.
b. Service bids must be in writing, itemize parts and materials and their costs, itemize labor items and their costs, and specify warranties on parts, materials and workmanship.
c. The price to be authorized is the lowest price quotation, unless justified, such as when the higher price quotation costs less for maintenance, repair or replacement, more nearly meets the needs of the individual, or provides greater safety, and is recommended for approval by the case manager.

The case manager must complete, sign and date a *Request for Approval to Authorize Services Form BAIS 0014)* and must enter the information into the INsite database. Thorough documentation supporting the *Request for Approval to Authorize Services Form BAIS 0014* must be entered into the INsite database by the case manager.

The case manager must verify the receipt of the following at the time the Request for Approval Form BAIS 0014 is electronically transmitted to the BDDS district office serving the county in which the individual resides:

a. Physician's order;
b. Medicaid prior authorization denial, when required;
c. Evaluation;
d. Service bids, including written explanation when less than three bids are available.

For services with costs of less than $5,000.00, the BDDS District Manager must review all requests for specialized medical equipment and supplies to assure the following:

a. The specialized medical equipment and supplies are allowable under current Medicaid Waiver guidelines; and
b. Necessary and properly completed documentation accompanies the request.

For services with costs of $5,000.00 or greater, the BDDS District Manager must electronically submit the information received from the case manager to the Waiver Specialist.

The BDDS District Manager (for services with a cost of less than $5,000.00) or the Waiver Specialist (for services with costs of $5,000.00 or greater) must indicate if the request is approved, approved with modifications, or denied on the *Request for Approval to Authorize Services* form in the INsite database. Once the "decision rendered" information is entered into the INsite database by either the BDDS District Manager or the Waiver Specialist, his/her signature will be electronically attached to the *Request for Approval to Authorize Services Form BAIS 0014* in INsite and electronically transmitted back to the case manager.

NOTE: Edits are in place to prevent the electronic transmission of *Form BAIS 0014* unless all required information has been entered.

The case manager must complete a *Notice of Action HCBS Form 5* and provide it to the individual or guardian and service provider. <u>If the request is denied, the case manager must notify the individual of his or her appeal rights.</u>

The case manager must oversee and inspect the timely completion of the service, consistent with the evaluation and approved bid.

Upon completion of the service consistent with the approved bid, the case manager must sign and date the *Request for Approval to Authorize Services Form BAIS 0014* and provide a copy of the form to the provider to submit with billing for the service and enter the completion information into the INsite database.

After the completion information is entered into the INsite database, the case manager may print out a completed *HCFA 1500 Form* for the provider to sign and submit along with the completed *Request for Approval to Authorize Services Form BAIS 0014* when billing for the service.

If the individual resides in a Medicaid-funded facility, the case manager may authorize the service provider to complete the service in advance of the individual's move if all of the following criteria are met:

a. The service must be necessary to enable the individual to move from the facility to home and community-based services;
b. The individual has been targeted for a Waiver slot and has a current level of care approval for the Waiver;
c. The *Request for Approval to Authorize Services Form BAIS 0014* has been approved by the appropriate BDDS District Manager or Waiver Specialist;
d. The service has been included in the individual's approved POC and CCB; and
e. The case manager shall not sign and date the *Request for Approval to Authorize Services (form BAIS 0014*) indicating completion of the service prior to the individual's move from the facility and starting Medicaid Waiver-funded services.

On a monthly basis, DDARS staff will run a report developed within the INsite database to identify any plans of care requiring a *Request for Approval to Authorize Services* form for which there is no electronic transmission of the form. DDARS staff will work with the BDDS district office and case manager to resolve the disparities.

On at least a quarterly basis, DDARS staff will run a report generated within the INsite database that randomly selects a number of services requiring a *Request for Approval to Authorize Services* form and complete thorough reviews of those services.

7.8 Senate Bill 30 Children

Senate Bill 30 is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are otherwise eligible for the Support Services Waiver.

Identification of the children involved will be made by the Intake or Ongoing Targeted Case Manager. A *Request for Information (HCBS Form 6*) will be sent to the child's local County DFC eligibility worker as an alert that the child is undergoing the evaluation process for approval of Waiver services. Upon receipt of this form, the DFC is to process the Medicaid case to the furthest extent possible without consideration of parents' income and resources pending receipt of verification of the Waiver, and then notify the case manager that the child is eligible pending approval of the Waiver.

For children who do not already have an active Medicaid case, the effective date of Medicaid and the effective date of the Waiver must be coordinated between the DFC eligibility worker and case manager. Similarly, the effective date of a new or changed spend down under this provision must coincide with the effective date of the HCBS Waiver.

The exclusion of parental resources and income applies only as long as the child is approved for the HCBS Waiver. Parental deeming resumes beginning the month following the month in which the HCBS Waiver was discontinued for the child who continues to live with his or her parents, in accordance with timely notice requirements.